CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR REGISTRATION OF INTERNSHIP – U.S. SCHOOL
INSTRUCTION SHEET

When to Register as an Intern

File this application form to register as a Delaware Pharmacist Intern if you:

- are in at least the first professional year of the pharmacy curriculum *or* have graduated from an accredited school or college of pharmacy ***in the U.S***., and
- wish to work in a Delaware Pharmacy to attain required hours of pre-licensure experience.

If you graduated from school or college of pharmacy *outside the U.S*., file the *Application for Registration of Internship-Foreign School* form instead.

If you have graduated and wish to take the NAPLEX, you must *also* submit an *Application for Pharmacist Licensure by Examination or Score Transfer* form.

Internship Program

To be licensed as a Pharmacist in Delaware, you must provide proof that you have completed 1500 hours of pre-licensure experience. The 1500 hours may include any combination of the following:

- Practicum hours you complete during or after your first professional year in your school or college of Pharmacy while under supervision of a pharmacist preceptor affiliated with the school or college
- Internship hours transferred from another jurisdiction(s) where you worked under the supervision of a licensed pharmacist preceptor
- Internship hours you work in a Delaware pharmacy under supervision of a Delaware-licensed pharmacist preceptor.

To work as an Intern in a Delaware pharmacy, you must select a Delaware-licensed pharmacist as your preceptor.

- The preceptor must agree agree to provide you with the experience outlined in the Board's Practical Experience Program.
- When you complete your internship hours or end your relationship with a preceptor, the preceptor must submit the completed *Affidavit of Intern Experience* form.
- If your preceptor changes, the new preceptor must submit a new *Affidavit of Preceptor* form *within ten calendar days* of the change.

For information on the internship program, read the *Practical Experience Program for Pharmacy Preceptors and Interns*.

Requirements for All Applications

The following items are required of all applicants. All auxiliary forms that you may need are included with this application.

☐ Submit completed, signed and notarized *Application for Registration of Internship – U.S. School*.

☐ Enclose non-refundable processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for the Board office to receive a *Certificate of Class Standing* form, sent *directly* from your school or college of pharmacy.

☐ Arrange for the Board office to receive the signed, notarized *Affidavit of Preceptor* form, sent *directly* from your preceptor to the Board office.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

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APPLICATION FOR REGISTRATION OF INTERNSHIP – U.S. SCHOOL

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle

2. Other Names Used: ☐ None _____ _____ _____
   (Include maiden, prior married, alternate spellings)

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____ ☐ None
   Home Work

EDUCATION INFORMATION

7. Enter the following about your pharmacy education:

   School or College of Pharmacy Name: _____

   Have you graduated? ☐ Yes ☐ No Enter the date that you graduated or expect to graduate: _____

   Arrange for your school to submit the *Certificate of Class Standing* form directly to the Board office.

PRECEPTOR INFORMATION

8. Name: _____ Delaware License: A1 - _____

   Arrange for your Preceptor to submit a *Affidavit of Preceptor* form directly to the Board office. When you complete your internship with this Preceptor, arrange for the Preceptor to submit the *Affidavit of Intern Experience* form.

DISCLOSURES

9. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ **If yes, submit a certified copy of a criminal history record from *each* jurisdiction where you have a record. For information on obtaining a Delaware criminal history record, click on State Bureau of Investigation.**

10. Are any criminal charges pending against you in any jurisdiction? Yes ☐ No ☐ **If yes, submit a certified copy of your criminal history record**.

11. Have you ever received an administrative penalty regarding your practice of pharmacy, including but not limited to fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a consent agreement containing conditions placed by a Board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, provide documentation of the regulatory Board action.**

12. Are you aware of any disciplinary proceedings or unresolved complaints pending against you in any jurisdiction where you have previously been or are currently licensed or registered? Yes ☐ No ☐ **If yes, provide documentation of the regulatory Board action.**

13. Do you have any impairment related to drugs, alcohol, or mental competence that would limit your ability to act as a pharmacist in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, submit a statement explaining fully.**

DUTY TO REPORT

14. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

15. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

16. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when
    - your license to practice pharmacy has been disciplined, surrendered, suspended or revoked, or
    - you have been convicted of a crime that is substantially related to the practice of pharmacy.

    I certify that I have read and understand 24 *Del. C.* §2515 (a)(8) and that I understand my *duty to self report*.
    Yes ☐ No ☐

    If Board review is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I do hereby make application to the Board of Pharmacy for license or registration under the provisions of an Act to regulate the practice of Pharmacy in the State of Delaware and solemnly swear and affirm that the answers to the questions set forth in this application are true and correct.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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CERTIFICATE OF CLASS STANDING

INSTRUCTIONS

This form is for applicants for a Delaware Pharmacist Intern license who are attending or graduated from a school or college of Pharmacy in the U.S.

- **The applicant completes the APPLICANT INFORMATION section and sends this form to his or her school or college of pharmacy.**
- **The Dean or Secretary of the college or school completes the information in the CERTIFICATION section, signs and seals the form and sends it *directly* to the Board office at the address above.**

APPLICANT INFORMATION

Applicant Name: _____

CERTIFICATION

1. Name of Pharmacy School or College: _____

2. Has the applicant graduated? Yes ☐ No ☐ If no, skip to the next question. If yes, enter the following information:
   Degree Awarded: _____ Degree Date: _____

3. Check which professional year of the pharmacy curriculum the applicant is in:
   - ☐ First professional year in pharmacy
   - ☐ Second professional year in pharmacy
   - ☐ Third professional year in pharmacy

4. Is the applicant a student in good standing? Yes ☐ No ☐

I certify that the above information is accurate.

Printed Name of Secretary or Dean: _____

Signature of Secretary or Dean: _____ Date: _____

AFFIX
INSTITUTION
SEAL

Send this form *directly* to the Board of Pharmacy office at the address above.

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AFFIDAVIT OF PRECEPTOR

INSTRUCTIONS

This form is for Delaware Pharmacist Intern applicants who are attending or graduated from a school or college of Pharmacy in the U.S.

- The applicant completes the APPLICANT INFORMATION section and sends this form to his or her selected Delaware-licensed preceptor Pharmacist.
- The preceptor completes the INFORMATION ABOUT PRECEPTOR section, signs the form in the presence of a notary and sends it *directly* to the Board office at the address above.

APPLICANT INFORMATION

Applicant Name: _____

INFORMATION ABOUT PRECEPTOR

1. Name of Preceptor Pharmacist: _____
2. Pharmacist License Number: A1 - _____
3. Have you practiced as a pharmacist at least two years? Yes ☐ No ☐
4. Name of Pharmacy Where Intern Will Work: _____
5. Pharmacy Address: _____

   _____ DE _____
   City State Zip
6. Pharmacy's License Number: _____
7. Do you accept responsibility as the preceptor for the applicant named above? Yes ☐ No ☐
8. Do you agree to provide the applicant with the experience outlined in the Board's Practical Experience Program?

   Yes ☐ No ☐
9. If you terminate your preceptorship agreement with the applicant, do you agree to notify the Board office within ten calendar days and to file an *Affidavit of Intern Experience* form? Yes ☐ No ☐

AFFIDAVIT

I hereby certify that the information I have provided is accurate.

Signature of Preceptor: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 9/2017